Alternate Care Operating Budget
Year:
Fiscal Data Collection Form

Annual Expenses

Name of Organization	
Program Name	
Number of Licensed Beds	

Direct Care Staff	**Hours/ Day**	**Total Hours Annually**	**Average Hourly Wage**	**Total Wages**
1st Shift - Weekdays		**0**	$ -	**$ -**
2nd Shift - Weekdays		**0**	$ -	**$ -**
3rd Shift AWAKE Weekdays		**0**	$ -	**$ -**
3rd Shift ASLEEP Weekdays		**0**	$ -	**$ -**
1st Shift - Weekends		**0**	$ -	**$ -**
2nd Shift - Weekends		**0**	$ -	**$ -**
3rd Shift AWAKE Weekends		**0**	$ -	**$ -**
3rd Shift ASLEEP Weekends		**0**	$ -	**$ -**
TOTALS		**0**		**$ -**
Paid Off Time (Vacation, sick, holiday…)		**300**	$ -	**$ -**
Total Direct Care Staff		**300**		**$ -**

Other Staff Costs (Excluding Direct Care Staff)	**# of FTE**	**Hours/Year**	**Hourly Rate**	**Annual Cost**
Support Staff (clerical, drivers, maintenance…)	0	0	$ -	$ -
Program Management Staff	0	0	$ -	$ -
Nursing	0	0		$ -
Supervisory Staff	0	0	$ -	$ -
Executive/Administrative Staff	0	0	$ -	$ -
Totals	0	0		-

Profit	**Annual Cost**		
Owner's Salary	$ -		$ -

Benefits And Taxes	**Annual Cost**	
Workers Compensation	$ -	
Unemployment	$ -	
FICA	$ -	
Health Insurance	$ -	
Retirement	$ -	
Long Term Disability	$ -	
Short Term Disability	$ -	
Life Insurance	$ -	
Other-	$ -	
Total Benefits	**$ -**	#DIV/0!

Other Staff Expenses		
Staff Training	$ -	-
Staff Mileage	$ -	-
Staff Recruitment, drug screens, background checks	$ -	-
Other	$ -	-
Total Other Staff Expenses	**$ -**	

Transportation	**Annual Expense**	
Vehicle Depreciation (or lease)	$ -	-
Interest	$ -	-
Gas, oil	$ -	-
Repairs and Maintenance	$ -	-
Insurance	$ -	-
License/Permits	$ -	
Public Transportation (bus & cab tickets)	$ -	
Other	$ -	
	$ -	
	$ -	
	$ -	
Total Transportation	**$ -**	

Other Operating Costs	**Annual**	
Office Occupancy Costs	$ -	
Insurance (other than property/casualty)		
Office supplies and furnishings	$ -	-
Office Telephone	$ -	-
Postage	$ -	-
Operating Fees/permits/licenses	$ -	-
Professional Fees		
Audit Fees	$ -	
Legal Fees	$ -	
Other	$ -	-
Indirect Overhead Costs(please identify costs)	$ -	-
Other		
Total Other Operating Costs	**$ -**	

Room and Board	**Annual Expense**	
Property Depreciation	$ -	-
Property Interest	$ -	-
Rent	$ -	-
Property/Casualty Insurance	$ -	-
Property Taxes	$ -	-
Building/Grounds Maintenance	$ -	-
Maintenance Salaries	$ -	-
Resident Food	$ -	-
Household Supplies	$ -	-
Household Equipment	$ -	-
Resident Furnishings	$ -	-
Utilities	$ -	-
Resident Phone	$ -	-
Cable TV	$ -	-
Other Housing Costs	$ -	-
Total Room & Board/Facility	**$ -**	-
Total Room & Board/Person	**#DIV/0!**	#DIV/0!
Daily Room & Board/Person	**#DIV/0!**	

Expense Summary		
Total Support and Services	$ -	-
DAILY RATE - Support	#DIV/0!	
Total Room and Board	$ -	-
DAILY RATE - R & B	#DIV/0!	
Total Program Cost	$ -	-
DAILY RATE - Total Program	#DIV/0!	
Indirect Overhead %	#DIV/0!	

Income Summary	
Care Support & Services	$ -
Other Contracts	$ -
SSI/Room & Board Payments	$ -
MAPC*	$ -
Hud Credit	
Other	$ -
Total	$ -

*Medical Assistance Personal Care

Name of Person Completing the Form	
Phone Number	
Date Completed	

Number of Family Living in Facility

Please enter data in unprotected cells. If entering a dollar amount in an "other" category, please change "other" to a descriptive name for that entry.

If living in the facility please see "Space Costs" section of the Allowable Cost Policy Manual.